MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address AmeriMed International P. Box 261353 Plano, TX 75026-1353	MDR Tracking No.: M4-04-0947-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	Date of Injury: Employer's Name: Personnel Plus, Inc Insurance Carrier's No.: 96 00000 142013

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5/8/03	**6/7/03**	**E1399 Rental of an Interferential Stimulator Unit – 2 months @ $249/month**	**$413.00**	**$413.00**

PART III: REQUESTOR'S POSITION SUMMARY

The carrier's representative is using this medium to try to sidestep the issue at hand, which is their reimbursement of the first DOS at the TENS MAR and denying the second DOS as needing preauthorization. The Interferential Stimulator is not a TENS unit and the cumulative rental is less than $500.00.

PART IV: RESPONDENT'S POSITION SUMMARY

The DME Ground Rules establish the standard for determining fair and reasonable reimbursement; preauthorization was not requested as required by rule; reconsideration was not requested prior to requesting Medical Dispute Resolution; and it is not clear if the injured worker received the item or benefited from the item in dispute. Based on the therapy rendered by the device in dispute, this carrier has no information to support reimbursement in excess of the reimbursement due for a TENS unit, much less a muscle stimulator.

Other bill copies of other DME provided to the injured worker about the same period of time were submitted for review.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Regarding jurisdiction, the fax confirmation page in the Requestor's Exhibit 5, reflects that 14 pages were received on 7/29/03 at the same fax number per the EOB instructions. The cover page for the request for reconsideration includes reference to both DOS in this dispute. However, reconsideration EOB was issued for only 5/8/03. This MDR request is dated 9/19/03 and thus makes the dispute for DOS 6/7/03 eligible for review per §§133.304(m)(2) and 133.307(g)(3)(A).

The EOB for DOS 5/8/03 reduced reimbursement to $85.00 with "40 – the charge for the services exceeds an amount which would appear reasonable when compared to the charges of other providers in the same geographic area." The response explains that this is the Respondent's effort at applying the 1991 DME fee schedule for the TENS unit as a fair and reasonable reimbursement. They have also described the billed unit as a "transcutaneous interferential nerve stimulator" which can be abbreviated to TINS and still not be the equivalent to the TENS unit.

The Respondent also contends whether the injured worker received the item or benefit from the item. However, since the respondent issued payment, there is a presumption that they have confirmed delivery of the item. The next issue would imply that medical necessity was in question. However, this denial reason is first mentioned after MDR was filed by the Requestor and is not a proper defense to be considered in this review (§133.307(j)(2)).

The cumulative total of the monthly rental in dispute does not exceed $500 to require preauthorization per §134.600(h)(11).

The Requestor provided copies of literature describing the functional benefits and differences of the Interferential Stimulator from other DME.

All the above establishes that the Interferential Stimulator is not the equivalent of a TENS unit, does not require preauthorization and reimbursement is subject to fair and reasonable reimbursement. The 1991 MFG does not include a MAR for the interferential stimulator. As established above, it is not the equivalent to the muscle stimulator either. The TENS reimbursement rate is not fair and reasonable. As the Respondent provided no other fair and reasonable alternative, additional reimbursement for the difference in the amount billed and the amount paid is recommended.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of **$413.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

	Patti Lanfranco	August 22, 2005
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____